ISSOP e-bulletin N° 15, May 2015
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1. Introduction

Welcome to the May e-bulletin and again we promote the ISSOP meeting in Geneva and hope to see many of you there – and a reminder that Geneva is very easy to reach by train so do please consider sustainable travel. We carry an interesting report from Baby Milk Action, several pieces of news from Latin America, a comment by Nick Spencer on the State of Inequality in Reproductive, Maternal, Newborn and Child Health and information on the tragedy that affects refugees (mostly children) in the Syrian Region. Have a good summer or winter (depending where you are...) and do please write in about the articles you have read.

Tony Waterston, Raul Mercer

2. Meetings and news

2.1 ISSOP in Geneva Sept 7-9 2015

The programme for workshops is now out in outline and includes the following topics:

- Child injuries
- Early childhood
- Economic and social determinants
- Adoption,
- Mental health
- Participation,
- Child health care
- Early interventions & disabilities
- Global Agenda for Social Paediatrics

The giant 'Broken Chair', a work of art in wood, symbolises the campaign against landmines. Geneva.

Confirmed keynote speakers:

- Monsieur l'Ambassadeur Michael Gerber
- MsGerisonLansdown
- Professor Zulfiqar A Bhutta
- Augustin Brutus Jaykumar
- Professor Nick Spencer
- Professor Philipp Jaffé

Further details and registration athttp://issop2015.org

Be there!

2.2. Report of ISSOP workshop in Ankara

International Society for Social Pediatrics (ISSOP)'s, 'Evidence Based Well Child Care' training course was held in May 14 -16, 2015 in Ankara, Turkey. We were very pleased to continue ISSOP Training Course tradition, dating back to 1970.

In this congress, our most experienced domestic and international colleagues presented the most current issues related to follow-up of healthy children. These presentations enriched by our participants' opinions, suggestions and experiences. Approximately, 250- 300 participants joined to our meeting. International participants were mainly from Kosovo, Azerbaijan, Georgia and Turkmenistan.

We hope this educational ISSOP meeting contributed to pediatricians and family physicians to question their practice of well-child follow-up and helped them do it according to the best evidence-based monitoring.

Gonca Yilmaz

2.3 Report from Baby Milk Action

The following report was circulated by Mike Brady of the UK organization Baby Milk Action and is relevant to our current campaign on conflict of interest.

Baby Milk Action runs a campaign calling on health workers and others to *"Say NO to formula company sponsorship".*

Under international marketing rules, manufacturers and distributors should not seek direct or indirect contact with pregnant women and parents. Health workers should guard against conflicts of interest and protect their independence.

So we were concerned when we learned The Guardian newspaper in the UK was organising a roundtable debate on nutrition for pregnant women and infants with sponsorship by Danone, the world's second largest baby milk company. We contacted the organisers in advance and submitted information explaining why this sponsor was inappropriate. The event went ahead regardless and a sponsored article then appeared in the newspaper that suited Danone's agenda very well. For example, promoting the idea that the government should work in partnership with the industry to target pregnant women with nutrition education.

We took the matter to The Guardian's Readers' Editor who conducted an investigation and published his conclusions this week (18 May 2015). His conclusion:

"I agree with the readers and think it was a mistake to go ahead with the Danone sponsorship because the subject of the debate could be interpreted as being too close to the subject of the controversy that has surrounded the company."

Danone is behind Nutricia, Aptamil, Cow & Gate and Nutrimum in the UK. Nutrimum is a new "ultra-processed" cereal bar aimed at pregnant and breastfeeding women. First Steps Nutrition has analysed them and said, "We believe these products undermine public health", for the reasons given at:
http://www.firststepsnutrition.org/pdfs/Statement_on_nutrimum_Mar_2015_final.pdf

Danone targets health workers, often in the guise of providing study days or support for information and training on useful topics. In our view it has become more aggressive since its main global competitor, Nestlé, entered the market with the takeover of the SMA brand.

Last month, we exposed a Nestlé job advertisement for its nutrition sales force. This makes it clear their *"role is to work on the designated territory, visiting hospitals, doctors, health visitors and community midwives to develop key clinical relationships within your local health Economies, leading to opportunities for the SMA brand and Nestlé Nutrition. Working with the NHS at a territory level, you'll be developing long-term, mutually beneficial relationships with key stakeholders and opinion leaders to support brand endorsement and strategically aligned education for Healthcare Professionals."* *(emphasis added).*See:
http://www.babymilkaction.org/archives/3653

Make no mistake, these are marketing staff seeking brand endorsements. While health workers may think they are immune to influence, the marketers clearly think otherwise.

We have produced a poster on *"Health workers, conflicts of interest and the baby feeding industry"* setting out the World Health Assembly Resolutions and other measures that address such sponsorship.

Report from Baby Milk Action (cont)

For those wishing to show their independence, we have a range of *"Say NO to formula company sponsorship"* mugs, key rings and fridge magnets.

Sometimes people say to me, *"but if we didn't take the money we wouldn't be able to do the good work we do"*. That reminds me that the Indian Paediatric Association decided over 20 years ago not to accept sponsorship from baby feeding companies and successively campaigned for a prohibition on sponsorship to be brought into law.

If doctors in India are prepared to make a stand, why not health workers in richer countries?

The International Society for Social Pediatrics and Child Health has called on the *"baby feeding industry to stop sponsorship of medical education"* (see our sponsorship poster for the link).

We will continue to raise the issue of conflicts of interest and hope those organisations that currently accept inappropriate sponsorship will follow The Guardian's lead. Here's the direct link to the Readers' Editor's article:
http://www.theguardian.com/commentisfree/2015/may/18/readers-editor-sponsorship-roundtables-chris-elliott

You can help us in this work by making a purchase from our Virtual Shop, sending a donation or becoming a member. You can also help spread this information by sharing the above links with colleagues and on social media.

Best wishes,
Mike Brady
Campaigns and Networking Coordinator

2.4 'Tigers' at RCPCH annual meeting

In the last e-bulletin we carried a report about the new film which was made in association with IBFAN on the Nestle whistle blower in Pakistan who exposed the corrupt practices in passing money and presents to paediatricians who recommend infant formula.

On the 28th April, a group of ISSOP members of the RCPCH arranged a showing of Tigers at the annual meeting in Birmingham, followed by talks including Dr Emmanuel Diamond (the paediatrician who informed the Nestle salesman of the harm being done to babies by infant formula), Patti Rundall of Baby Milk Action and Dr Delan Devakumar the chair of the RCPCH advocacy committee. There was a very lively discussion on the ethics of infant formula sponsorship of the RCPCH and the debate is ongoing. The film itself is a superb exposition of the risks of taking money from the Baby food industry and should be shown more widely. We are hoping to obtain it for the ISSOP annual meeting in Geneva.

Tony Waterston

2.5 The 2nd Virtual Conference on Social Pediatrics: "Beyond the Ramps. Health inclusion for people with disabilities". (In Spanish)

The Committee of Social Pediatrics ALAPE (Latin American Association of Pediatrics) is pleased to invite the professional community to the second virtual online conference (webinar). Our guest speaker is Sergio Meresman, Master in Community Health (University of Liverpool, England) and inclusive development specialist. He is currently Project Coordinator of Inter-American Institute on Disability and Inclusive Development (IIDI) is doomed to study and development of equity in health programs focusing on children and women with disabilities in collaboration with The Partnership for Child Development (PCD) and UNICEF.

Link to the conference: https://flacso.adobeconnect.com/pediatriasocial2015
Information: alape.pediatria.social@gmail.com

We look forward to your participation

Sincerely,
Dr. Ernesto Duran Strauch
Coordinator of Social Pediatrics Committee ALAPE

2.6 13th Argentine Congress on Social Paediatrics and Children's Rights 8th Argentine Congress of Breastfeeding - 12, 13 and August 14, 2015

Center of Pediatric Teaching and Training "Dr. Carlos A. Gianantonio"
(Salguero 1244) Palais Rouge Events and Conventions (Salguero 1441) Buenos Aires.
Information and Registration: SAP (Sociedad Argentina de Pediatría) - Av Coronel Diaz 1971 --1425 - Buenos Aires – Argentina.
Phone: (54-11) 4821-8612 - Fax: (54-11) 4821-8612 ext. 101
E-mail: congresos@sap.org.ar - Web: www.sap.org.ar

2.7 Echoes of the second Colombian Congress of Social Pediatrics

It was held in the city of Medellin the II Colombian Congress of Social Pediatrics, organized by the Committee of Social Paediatrics of the Colombian Society of Paediatrics. Its central theme was the promotion of health and the rights of children and adolescents.

It was attended by a large group of professionals in the areas of health, social sciences and pedagogy from different regions. Children and adolescents from Medellin, participated through their contribution to understand how life develops in their communities and the projects they have built to promote a peaceful city, that protects childhood and adolescence.

As pre-congress activity participants visited the town of Támesis (Thames), where they visited health services focused on health promotion with rights approach.

It featured a section of research in which the diversity of themes that addresses today's Social Paediatrics in the country.

Photo (R Mercer) Colombian truck (CHIVA) used for field activities of health promotion at the community level
More information in: http://pediatriasocialalape.blogspot.com.ar/2015/04/congreso-ii-colombiano-de-pediatria.html

3. International Organisations

3.1 IPPNW www.ippnw.org

Whilst not a child health organisation, IPPNW is of great importance to our specialty since its focus is war prevention, in particular nuclear war.

Founded in 1980 during the height of the cold war, IPPNW is based on the principles that doctors and health professionals should work together across national boundaries to end war and violent conflict. It was originally founded by an American and Russian cardiologist who felt that their patients were more at risk from nuclear war than from heart attacks. Since then the organisations has grown in number to tens of thousands of doctors with affiliates in 64 countries, winning the Nobel Peace Prize in 1985 only 5yrs after its foundation. IPPNW has been instrumental in both global and regional conflict reducing initiatives, for example the campaign against small arms in Africahttp://www.ippnw.org/afp.html . IPPNW created ICAN, the International Campaign to abolish Nuclear Weapons http://www.icanw.org which is seeking a nuclear weapons convention on the lines of the chemical and biological weapons conventions.

The recent non-proliferation treaty conference in New York ended disappointingly without a conclusion, https://www.opendemocracy.net/5050/rebecca-johnson/npt-107-nations-pledge-to-negotiate-on-nuclear-disarmament
but the good news is that 107 nations have now signed the pledge to end nuclear weapons on humanitarian grounds, ending with the words

'*We pledge to cooperate with all relevant stakeholders, States, international organisations, the International Red Cross and Red Crescent Movements, parliamentarians and civil society, in efforts to stigmatise, prohibit and eliminate nuclear weapons in light of their unacceptable humanitarian consequences and associated risks.*'

Was your country one of the ones that signed the pledge? Find out at http://www.icanw.org/pledge/ and if not, why not write to the government to ask them to do so?

You can find a model letter at http://goodbyenuk.es/take-action/

Tony Waterston

3.2 Social Paediatrics blog from Latin America (in Spanish)

The Committee of Social Paediatrics of ALAPE (www.alape.org) has a blog where news of interest can be found on social paediatrics in Spanish. Those who are interested can access the next link http://pediatriasocialalape.blogspot.com.ar/

4. Current controversy

4.1 Should WHO open its doors to corporate influence?

We reprint here a Press release from IBFAN (International Baby Food Action Network) which was issued at the recent World Health Assembly in Geneva, UN Palais, May 18th, 2015

WHO opens the doors wide to corporate influence?

The long-running debate about how WHO interacts with corporations is coming to crisis point. In the context of its Reform Process WHO Secretariat has been working on a new *Framework of Engagement with non-State Actors* - a term which applies equally to corporations, big philanthropies and public interest groups.

The International Baby Food Action Network (IBFAN) has been following this issue for many years and is calling for the negotiations to be put on hold and for the work to be informed by an expert meeting on Conflicts of Interest with public participation, with the aim of ensuring that WHO is protected from undue corporate and funder influence and stays true to its constitutional mandate.

During the discussions at regional and global level, the concerns of many Member States have not been taken seriously. African countries, for example, have stressed that*"WHO should proceed with caution in developing a policy on engagement with non-State Actors"* and specifically called for a "*clear policy on how WHO will manage its conflicts of Interest."* In contrast the Regional Committee for Europe has been pushing for speedy adoption of the Framework.

The resulting Framework that Member States will be asked to approve this week, although claiming to address the key issues, is totally inadequate and fails to achieve the safeguards called for. Significantly the entire conflict of interest section is still in brackets (and might even be deleted) and the conflict of interest definition wrongly confuses the legal definition of conflicts of interest which refers to conflicting primary and secondary interests *within* an institution with conflicts *between* actors.

There seems to be a lack of political will to sort out this critical component of much needed comprehensive, coherent and effective public interest safeguards in the face of giant companies and private funding for public purposes. Instead the document refers frequently to the need for *'mutual respect'* and *'trust'* and proposes that a key principle for relations with WHO is inclusiveness of all actors.

The proposed framework would do nothing to address the corporate influence that is already being channeled by groups such as the *Global Health Council* with its 78 members from the corporate, voluntary, academic sector. This year GHC has permission to bring 101 delegates to the Assembly without any requirement to register of provide information on their credentials.

A new industry body that is eager to get official relations status with WHO isthe International Food and Beverage Alliance (IFBA) representing Big Food corporations, Nestle, Ferrero, Coca Cola, Mars, McDonalds and PepsiCo.

IBFAN is calling for a debate about the structural causes of the crisis in global health governance and how best to assure adequate core funding of WHO.

Member States contributions

Since the US pressured for a freeze of the budgets of UN agencies in the 1990s, Member States untied funding represents only a fifth of WHO's total budget. If WHO is to fulfil its constitutional mandate the budget must be unfrozen. The Ebola crisis showed how prime functions of WHO have been drastically weakened by reliance on 'voluntary' funding that is tied to specific programmes with conditioned mandates. Why would it be so difficult to unfreeze when the budget is a fraction of the economic costs caused by the delayed response to the latest Ebola outbreak?
Some Member States pushed WHO to open up to corporate funding at the start of the Reform process in 2010. At the time WHO Director-General, Dr Chan proposed to accept to funding from the private philanthropies and commercial sector. She promised this could be done *"without compromising independence or adding to organizational fragmentation."* In fact, it introduced a grave institutional conflict of interest. The proposed Framework now seems to deliver the payback in terms of corporate influence.

It fails to deliver on demands made by Member States at the last WHA when they rejected the draft Framework: They had asked for guidance on how to discern which relationships are appropriate, and more specifically for guidance on issues related to private sector relations including conflicts of interest.

If the Framework is adopted without addressing this request, any much needed budget increase may end up in the pockets of pharmaceutical transnationals while allowing Big Food to continue undermine marketing regulation of junk food which causes so much harm in terms of human health, lives and public health economies. Who would bite the hand that feeds it?

5. CHIFA report (formerly CHILD2015)

CHIFA membership is now up to nearly 3000 members, with very active recent discussions on corporal punishment, videos on breastfeeding and health information on newborn care. We hope to report soon on the development of a Spanish wing of CHIFA with the involvement of the Pan American Health Organisation. As ever do please contribute to the forum and emulate our most active ISSOP member, Dr Gonca Yilmaz.

Tony Waterston

6. Recent publications

6.1 Comment by Nick Spencer on WHO report on Inequalities in Health

State of Inequality: Reproductive, Maternal , Newborn and Child Health

WHO have published a report on inequality in reproductive, maternal, newborn and child health (RMNCH) that should be of interest to ISSOP members http://www.who.int/gho/health_equity/report_2015/en/ .The report, prepared by WHO working with the International Center for Equity in Health, Pelotas, Brazil, gives the latest status of inequality in RMNCH in 86 low and middle income countries as well as information on changes in inequality over the last 10 years in a subset of 42 countries with available data.

Overall, inequalities were to the detriment of women, infants and children in disadvantaged population subgroups; that is, the poorest, the least educated and those residing in rural areas had lower health intervention coverage and worse health outcomes than the more advantaged. In a minority of cases, child health interventions or outcomes were unequal between boys and girls.

Reproductive health indicators showed marked inequalities:

- The proportion of **births attended by skilled health personnel** differed by up to 80 percentage points between the richest and poorest subgroups; this difference was 37 percentage points or higher in half of countries.
- In half of countries, **antenatal care coverage (at least four visits)** differed by at least 25 percentage points between both the most and least educated, and the richest and poorest.
- **Antenatal care coverage (at least one visit)** was at least 10 percentage points higher among women in the richest subgroup than those in the poorest subgroup in half of countries.

Reproductive health intervention indicators also indicated a situation of inequality.

- The **use of modern contraception** was at least twice as high among women with secondary schooling or higher than among women with no education in nearly half of countries.

Immunisation indicators, by contrast, showed a much more equal distribution:

• Countries demonstrated no – or very low levels of – sex-related inequality in immunisation coverage. The difference in **immunisation coverage** between boys and girls did not exceed 10 percentage points in any study country.

• Looking at **BCG, polio, measles** and **DTP3 immunisation among one-year-olds,** in each case there was a difference of less than 5 percentage points between coverage in rural and urban areas in half of countries.

• Over one third of countries reported a gap of less than 5 percentage points between **BCG immunisation** coverage in the richest and poorest subgroups.

Child health outcomes showed marked inequalities:

• A large majority of countries reported a higher **under-five mortality rate** in rural than in urban areas. In half of countries, the difference between rural and urban areas exceeded 16 deaths per 1000 live births.

• **Stunting prevalence in children aged less than five years** was elevated by as much as 39 percentage points in the children of mothers with no education compared with those children whose mothers had attended secondary school or higher. In half of countries, the education-related difference between these two subgroups was 15 percentage points or more.

Early initiation of Breast-feeding was the only indicator to show some countries with pro-poor inequalities:

• About the same number of countries reported pro-poor inequality in **early initiation of breastfeeding** (higher prevalence of breastfeeding in the poorest than in the richest subgroup) as reported pro-rich inequality (higher prevalence in the richest than in the poorest subgroup). Overall, there was no prevailing pattern in economic-related inequality in breastfeeding practices across countries.

Change in inequality over time:

There was an encouraging trend in many of the indicators and many countries for inequality to decrease with a tendency for improvements to be greater in more disadvantaged groups compared to the more advantaged. This was particularly noted in relation to immunisation. For the major child health outcomes, the trends differed:

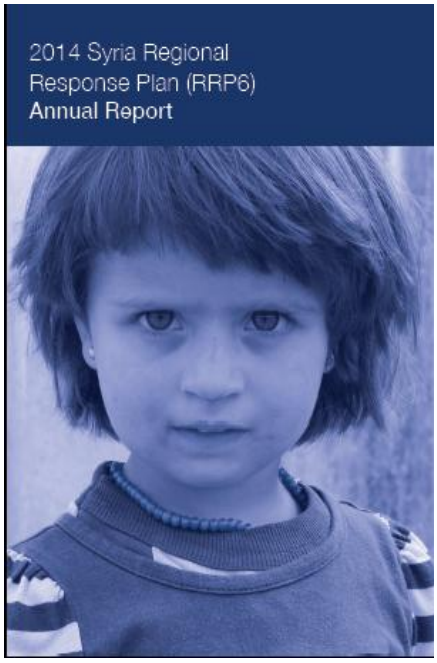
• The **under-five mortality rate** decreased more rapidly in the poorest than in the richest subgroup, by a margin of at least 26 deaths per 1000 live births over a 10-year period.

• Comparing the pace of change in **stunting prevalence among children aged less than five years** in the poorest and richest subgroups revealed divergent patterns across study countries. Several countries reported a strong pro-poor situation (changes in prevalence favoured the poorest subgroup) whereas several other countries reported a pro-rich situation (changes in prevalence favoured the richest subgroup). Overall, there was little indication that economic-related inequality in stunting prevalence had decreased globally.

6.2 2014 Syria Regional Response Plan (RRP6) Annual Report

With the conflict in Syria continuing to cause loss of life, injury, and destruction, as well as displacement on a large scale, RRP6 partners continued to advocate for admission to safety of those feeing violence in Syria and to identify and assist the most vulnerable refugees, including female headed households, children, the elderly, persons identified as having specific needs and survivors of sexual and gender-based violence (SGBV). Registration, including through iris scanning, continued to play a pivotal role in identifying and addressing specific needs and vulnerabilities, however challenges remained in relation to the need for mobile registration teams and special registration modalities for persons with specific needs.

By the end of 2014, Syrians had become the largest single refugee population under UNHCR's mandate, with almost 3.8 million Syrian refugees registered in the Republic of Turkey (Turkey), Lebanese Republic (Lebanon), the Hashemite Kingdom of Jordan (Jordan), the Republic of Iraq (Iraq), and the Arab Republic of Egypt (Egypt). While over 1.5 million refugees were registered during 2014, borders became increasingly managed making access to safety constrained. These difficulties have resulted in a decline in the number of newly arriving registered refugees and in their ability to access critical international protection.



Full report in:
http://data.unhcr.org/syrianrefugees/regional.php

7. Correspondence

'When I raised the question of infant formula sponsorship with my national paediatric association, they said that we work with the companies because some mothers have to use formula milk, and they have a valuable role in setting up educational meetings. Many doctors depend on these meetings and on other contacts for their continuing medical education. They say that doctors in our country are not well paid and could not afford expensive fees to attend meetings. How should I respond to this viewpoint?'
(*written by a member who prefers to remain anonymous*)

Editor: we asked Adriano Cattaneo, an international expert on the Baby food industry and a member of the ISSOP Conflict of Interest Group to reply to this letter.

If you really think that companies have a valuable role in setting up educational meetings, please attend. We at ISSOP and many other paediatric associations think that the primary and only objective of the sponsors is to promote their products and brand, and to create conflicts of interest: will the information they provide be truly objective? Regarding attendance at expensive meetings, please consider cheap alternative and more useful options. Small cheap local meetings, organised around real and practical issues, and in which learning is based on peer education and is free from commercial interests, have been shown to be more effective in improving practices than huge gatherings often centred on big (and biased) science presented by so called key opinion leaders full of conflicts of interest.

Adriano Cattaneo